Governor's GMAP Forum on Health Care

Implementation of the Governor's Health Care Goals, Strategies & Initiatives

April 20, 2006

Please visit our Website at:
http://www.gmap.wa.gov

What is this GMAP focusing on?

- The September 15, 2005 GMAP focused on broad state-wide results measures surrounding quality, efficiency, and access to health care, as well as the overall health status of people in Washington.
- Since that time the Governor has articulated specific goals, strategies, and initiatives; legislation and budget changes have been enacted; and agencies have started to act.
- This GMAP focuses on the implementation of the Governor's health care initiatives, focusing on **initial milestones and measures** that will be used to gauge results.

Where will we go from here?

- Implementation will bring new knowledge and lead to refinement and adjustment of the initial milestones and measures in this report. New initiatives or challenges may also emerge. In addition, there are many other state agency programs and activities that contribute on an ongoing basis to the Governor's health care goals. Over the next several months, OFM and the GMAP office will be working with state agencies through a coordinated process ("POGMAP") to align the multitude of measures used for management and accountability in the area of health care. This work will be reviewed at the next GMAP on July 12.

What are the Governor's Goals, Strategies, and Current Initiatives?

Governor's Health Care Goals:

Improve Quality and Efficiency
Increase Access to Health Care
Improve People's Health

"I believe that the state, by developing sound health care purchasing policies for…1.3 million people, can be an example of innovation and fiscal accountability for Washington's health care industry."

"Government must play a leadership role in promoting prevention and wellness."

Governor Chris Gregoire, January 2006

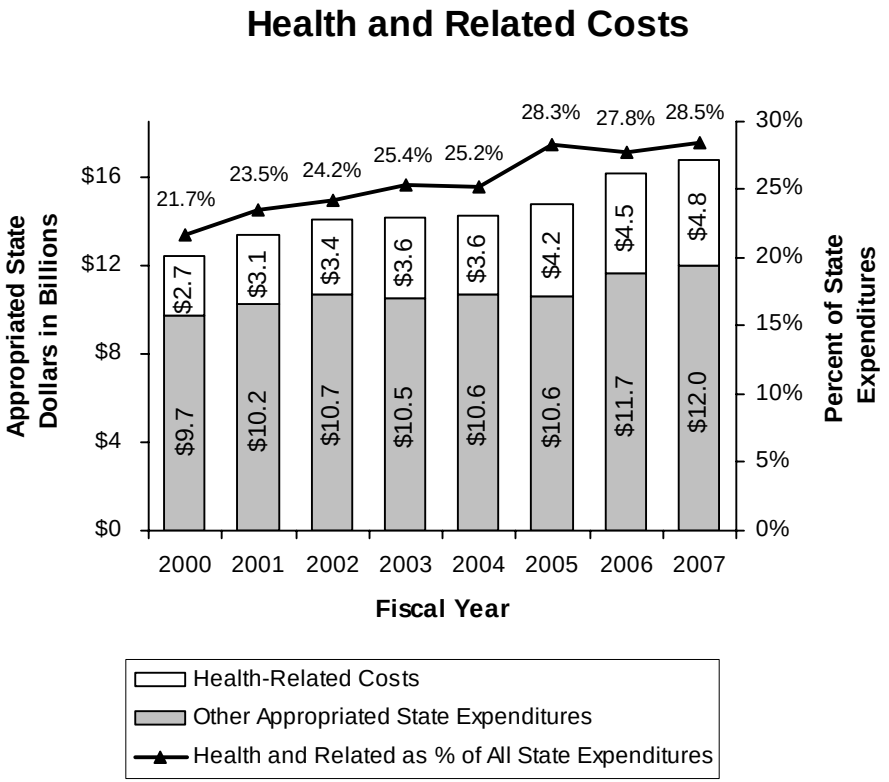
	SLIDES 5-7, 26	SLIDES 8-10	SLIDES 11-14	SLIDE 15	SLIDE 16	SLIDES 17-20	SLIDE 21	SLIDES 22-24
Strategies	*Emphasize Evidence-Based Care*	*Promote Prevention, Healthy Lifestyles, and Healthy Choices*	*Better Manage Chronic Disease*	*Create More Transparency in the Health Care System*	*Make Better Use of Information Technology*	*Increase Children's Health Care Coverage*	*Address Critical Gaps in Affordability*	*Improve the Health of the People in Washington*
Current Initiatives	Assess health technologies and procedures	Operate a state-employee prevention program (Washington Wellness Works)	Improve chronic care management for medicaid clients and state employees	Increase reporting of health quality and efficiency data	Increase use of electronic medical records	Continue support of state-paid health care programs for children	Cover medicare pharmacy co-payments	Improve nutrition in schools
	Use outcome data in state contracts	Expand use of on-line employee health assessments	Increase use of chemical dependency treatment			Encourage employer-sponsored insurance (ESI) for low-income families		

NOTE: SUPPLEMENTAL SLIDES BEGIN ON PAGE 25

What have we accomplished since the last forum?

- Governor's Health Care Summit (October 2005)
- Governor's 5 Point Strategy on Quality and Efficiency (November 2005)
- Governor's Directives on Employee Wellness, Chronic Care Improvement, and Outcomes (January 2006)
- Medicare Part D Pharmacy Co-Pays Assumed by State (January 2006)
- 2006 Legislative Session
  - Passage of Governor Request Legislation:
    - technology assessment (E2SHB 2575)
    - health information technology (SHB 2573)
    - repeal of medical premiums on children up to 200% federal poverty level (SHB 2376)
  - Budget Authorizations:
    - health risk assessments
    - expansion of Children's Health Program to 14,000 non-citizen children
    - additional vaccines for Washington's immunization program
- Public Employees Benefits Board's actual 2006 cost increase trend to date (8%) is running lower than both budgeted increase (8.5%) and projection (11%).
- Continued enrollment increases in the Child Profile Immunization Registry
- Significant on-going cross-agency work to plan, communicate, and begin implementing the Governor's Initiatives.

Why are we taking action to improve quality and efficiency?



Analysis

- The state provides health care to about 1.3 million Washington children and adults.
- Health and related costs are consuming larger portion of State resources each year. These are dollars not available for education, wages, and other social benefits.
- By developing sound health care purchasing policies, the state can be an example of innovation and fiscal accountability for Washington's health care industry.

Actions

- Evidence-Based Care
- Prevention, Healthy Lifestyles, Healthy Choices
- Chronic care management
- Transparency
- Information Technology

Data notes: Source: State of Washington Office of Financial Management (July 2005). Health and related costs include Medicaid, Basic Health, public health; plus long-term, institutional, and behavioral health costs.

How do costs for public employees compare?

Analysis:

Washington's public employee health care costs are greater than and have risen faster than other public and private employers

Strategies:

Improve Public Employees Benefits Board (PEBB) procurement strategy by:

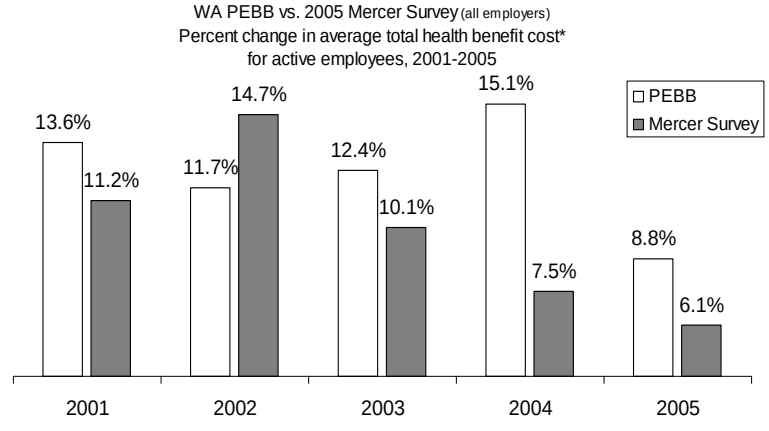
- Consolidating plans
- Add offerings that compete with Uniform Medical Plan
- Improve Uniform Medical Plan network management, care management, and consumerism

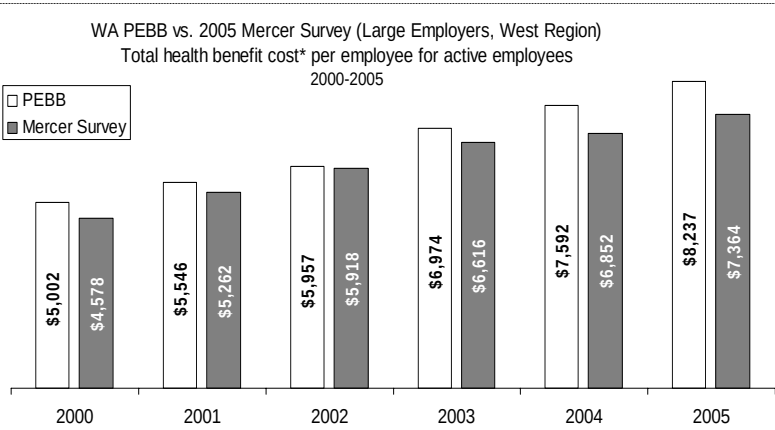
Performance Measures:

1. % increase in PEBB per-employee-per-year costs
2. % increase in PEBB premium cost

Targets:

1. % increase at or below WA large employers* by 2007
2. Within 150% of State revenue growth rate** by 2008





Data notes: * Costs includes medical, dental, vision, and pharmacy. **Source:** HCA Financial Services & Mercer National Survey of Employer-Sponsored Health Plans.

**As reported by OFM.

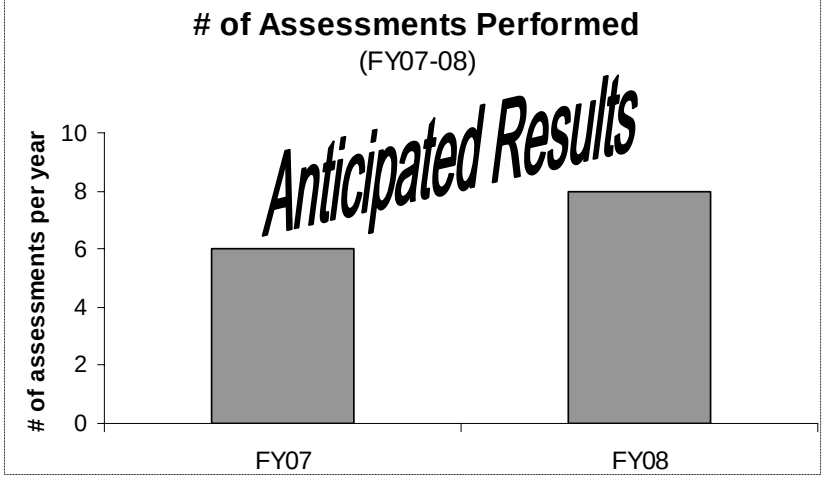
How are we incorporating evidence-based medicine principles in our purchasing?

Objective:
Ensure that the State provides health care that works and does not harm people.

Strategy:
Review medical and scientific evidence to assess new and existing medical technologies to determine how the State will provide coverage.

Performance Measure:
1. Number of technology assessments performed by the new State Health Technology Assessment Program (SHTAP)

Targets:
1. Interim target: 3 technologies chosen by Jan '07 and assessed by Mar '07.
2. Project target: 6 technology assessments in FY07, and 8 assessments in FY08.



Major Project Phases
- 2005/06 – Legislative activities to create SHTAP (ESSHB2575)
- 2006/07 – Create SHTAP center
- March 07 – 3 technology assessments complete
- Ending FY07 – up to 6 technology assessments
- Ending FY08 – up to 8 technology assessments

Notes: 2006 supplemental budget provides $1.2M & 4 FTEs to HCA in FY07. Agencies included for adoption of coverage decisions are Department of Social and Health Services, Health Care Authority, and Labor & Industries (Department of Veterans Affairs and Department of Corrections may also be included)

What is the plan for implementing the prevention program called Washington Wellness Works, and how will we measure results?

Objective:

Reduce state healthcare costs and **increase productivity** by bringing about lasting behavior changes of state employees, retirees and their dependents

Strategy:

•Implement the Governor's Directive on Employee Wellness: Washington Wellness Works

•Promote physical activity and healthier eating strategies and increase participation

•Reduce use of all tobacco products among state workers

Performance Measures:

•Milestones reached compared to plan

•No. employees/retirees who participate in tobacco cessation

•No. employees/retirees who participate in physical activity

•Status of healthy eating education

Targets:

•Targets to be determined after Health Risk Assessment results, May 2007;

•June 2006, UMP baseline

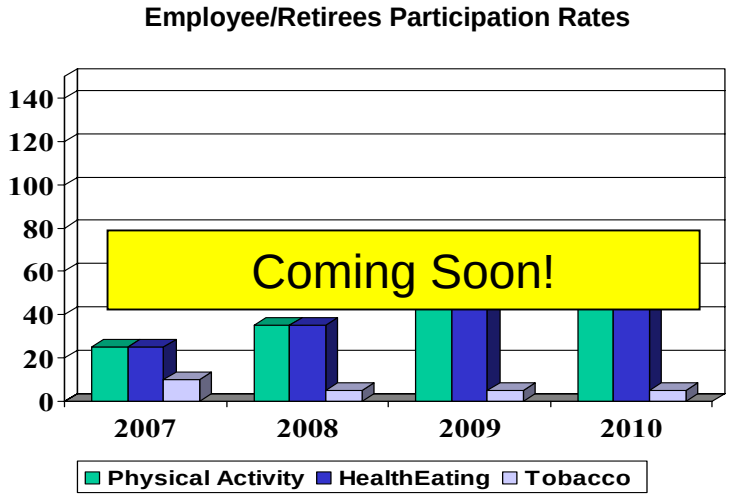
•October 2006, Group Health baseline

Analysis and Action:

•Approximately 320,000 members will be targeted

•HCA and DOH share the lead

•Best practices will be incorporated



Milestones

- January 2006 – W3 workgroup engaged
- April 2006 - Work with UW to design evaluation tool and HRA for lives not covered by UMP & GH
- June 2006 - Health & Productivity Committee meets
- July 2006 - Launch HRAs and review data
- July 2006 - Select Wellness Coordinators
- August 2006 - Design intervention strategies
- Oct 2006 - Train Wellness Coordinators
- July 2007 – Evaluate components

Data notes: WWW data; statistics from online HRAs

How will health risk assessments be implemented?

Objective:

Reduce state healthcare costs and **increase productivity** by bringing about lasting behavior changes for all state employees, retirees and dependents.

Strategy:

Offer an online Health Risk Assessment (HRA) to gather data about health risks and behaviors of state enrollees.

•5 out of 8 plans representing 88% of enrollment already have an HRA, including Uniform Medical Plan (52%) and Group Health (30%)

•HCA will create a tool for the remaining 3 plans (12%)

Performance Measures:

•Participation in the HRA and interventions

•Percentage increase in preventive services from 05-06

•Percentage increase in *Free & Clear* or other tobacco cessation programs

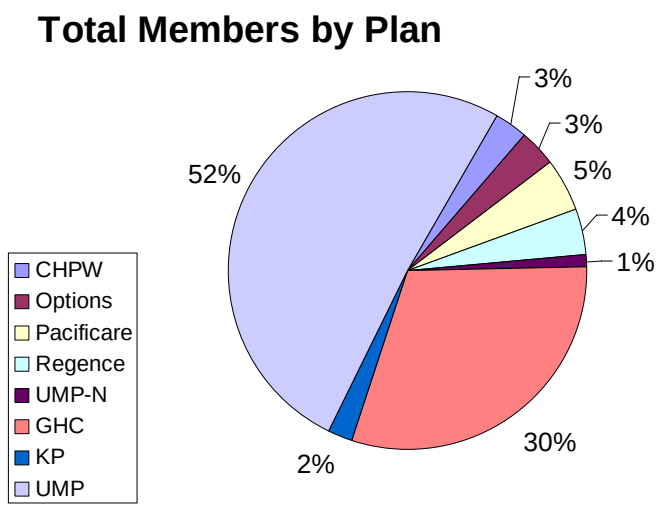
Targets:

•30 percent participation in the HRA.

•Targets to be determined for increases in preventive services and *Free & Clear* or other tobacco cessation.

Challenges:

•Developing a tool that accommodates each health plan's benefit design.



Milestones for HCA Tool

- May 2006 - Design tool and evaluation with UW
- May 2006 - Work with Group Health on their tool
- June 2006 - Complete beta test
- June 2006 - Baseline claims data for goal setting
- August 2006 - Go Live

Data notes: WWW data; statistics from online HRA and from Group Health

How will health risk assessments promote prevention?

Uniform Medical Plan's eHealth Survey and Health Counts Program = 52% of HCA Enrollment

Objective:

Reduce state healthcare costs and **increase productivity** by bringing about lasting behavior changes for Uniform Medical Plan (UMP) enrollees

Strategy:

•Offer eHealth Survey (Health Risk Assessment - HRA) to gather data about the health risks and behaviors of UMP enrollees.

•Health Counts (Wellness Program) will offer a $30 premium rebate to enrollees for healthy behaviors and getting recommended preventive services.

Performance Measures:

•Participation in the HRA and Health Counts

•Percentage increase in preventive services from 05-06

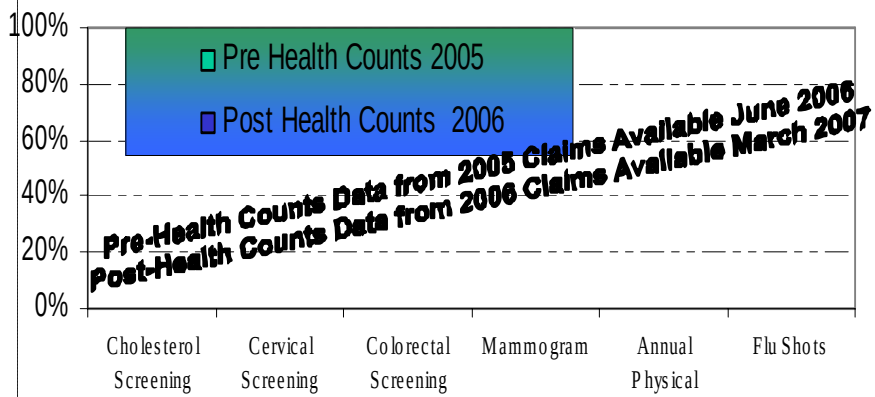
•Percentage increase in *Free & Clear* (smoking cessation) enrollment

Targets:

•30% Participation in the Health Counts program.

•Targets to be determined for percentage increases in preventive services and *Free & Clear* (smoking cessation) enrollment.

Percentage of Targeted Enrollees Getting Preventive Services



Analysis and Action:

•HRA developed in coordination with UW - completely confidential web-based, individualized questionnaire.

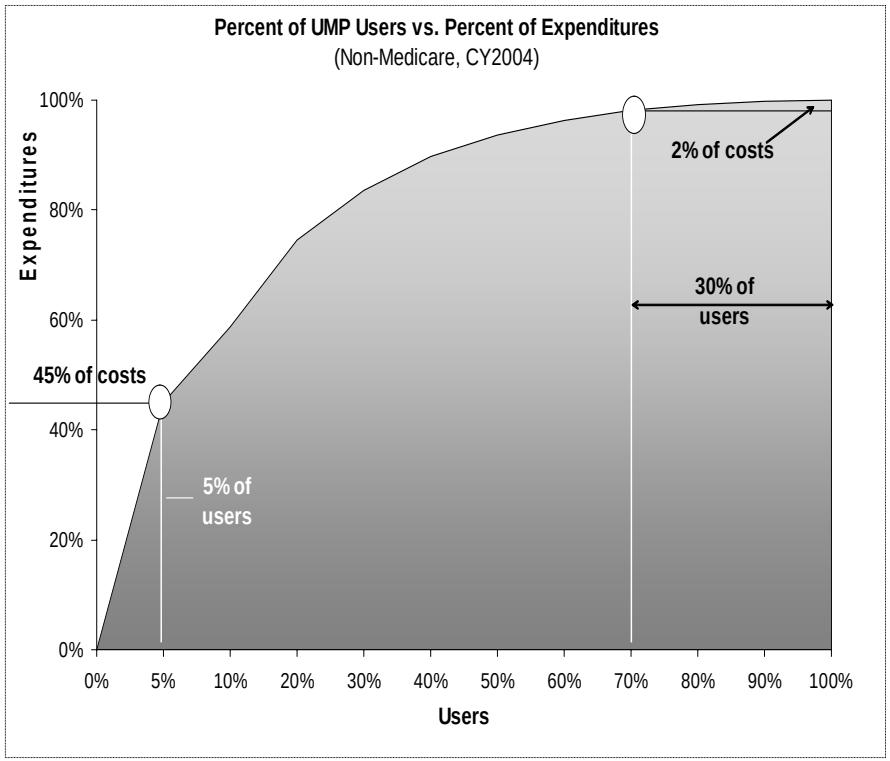
•Questions from Behavioral Risk Factor Surveillance System (BRFSS) to compare nationally

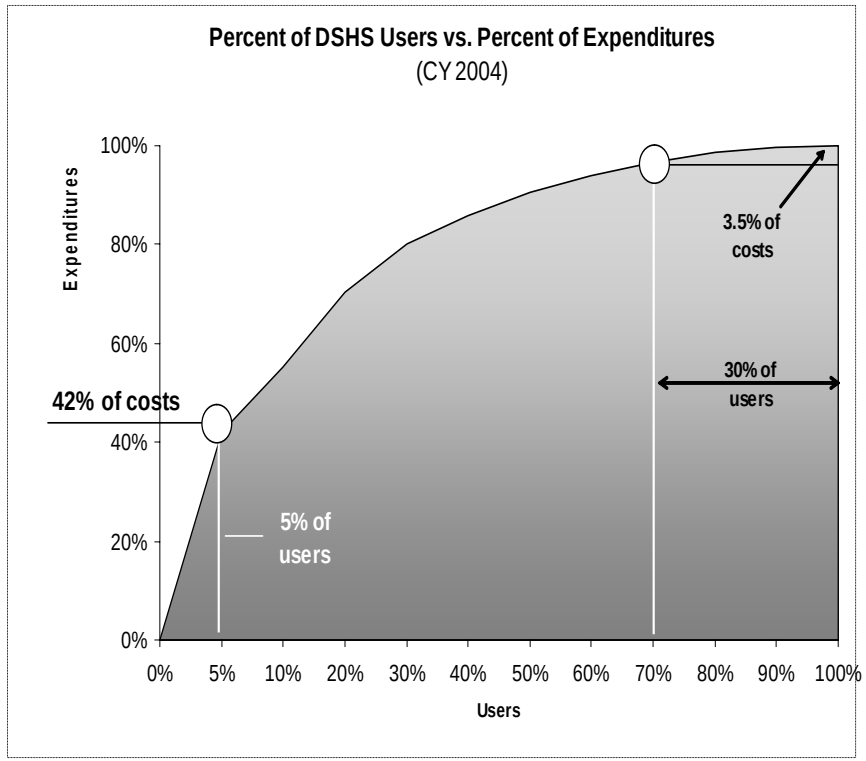
•To qualify for $30 premium rebate, enrollees must complete HRA and earn points for preventive services

Data notes: UMP data; statistics from online HRA and Health Counts scorecard.

Why are we trying to better manage chronic disease?

- Top 5% of HCA UMP enrollees are responsible for 45% ($153 million) of expenditures.
- Top 5% of DSHS Medicaid Fee-For-Service enrollees account for 42% ($1.2 billion) of expenditures.





Data notes: Sources: 2004 Uniform Medical Plan claims. 2004 DSHS Medicaid Management Information System.

What are we doing to better manage chronic disease?

DSHS & HCA & DOH to jointly analyze high cost enrollees to determine if care management strategies could reduce medical costs and improve health status.

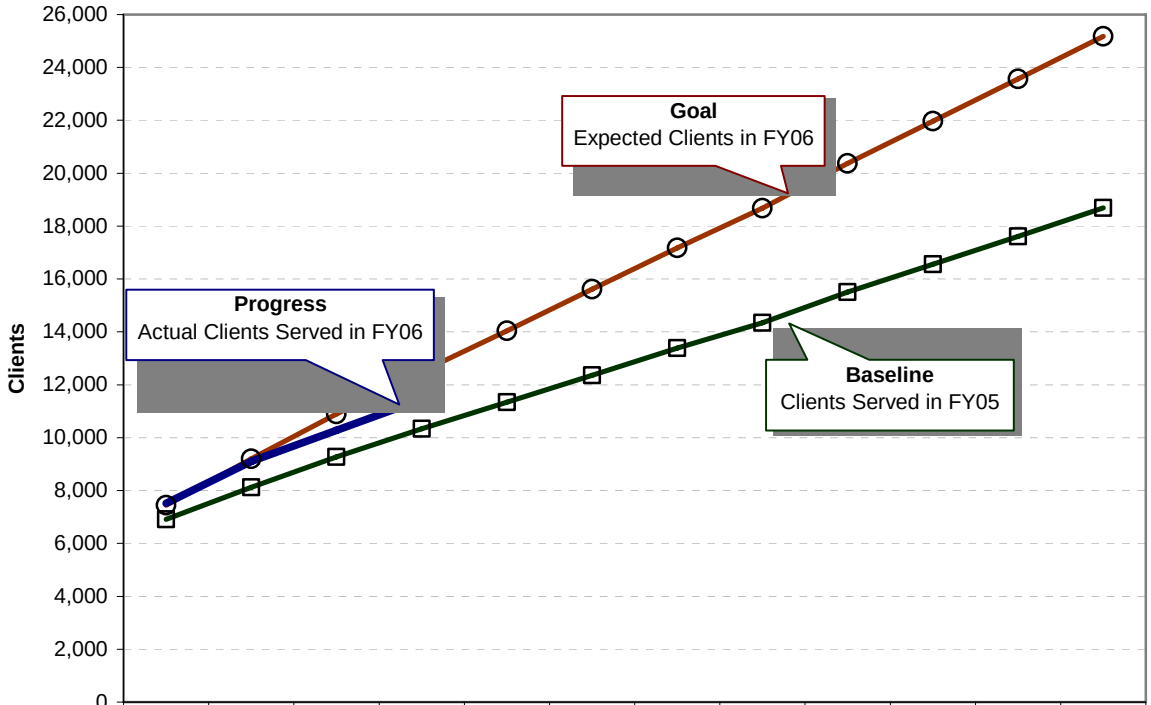
ACTION PLAN	AGENCIES	STATUS
Establish across-agency (DSHS, HCA, DOH) workgroup.	DSHS, HCA & DOH	Completed
Conduct preliminary analysis of 5/50 populations to determine if HCA and DSHS have common risks.	DSHS & HCA	Completed
Conduct evaluation of predictive modeling applications to determine whether existing models can predict populations that may become very high cost.	DSHS & HCA	April 2006
Decision package request to purchase predictive modeling modules for agencies.	DSHS & HCA	June 2006
Survey agencies current care management interventions and compare to "best-in-class" interventions in public and private sector. (Mercer Contract)	DSHS & HCA	May 2006
Develop one or more pilot interventions for the 5/50 population.	DSHS & HCA & DOH	January 2007
Share predictive information and high opportunity populations with agencies current care management programs to ensure access to care.	DSHS & HCA	To Be Determined
Develop "measures of success" to identify areas of cost savings and improved health that can be measured and reported.	DSHS & HCA	To Be Determined
Develop new patient/provider-centered model of disease management for Medicaid clients that: - Supports "medical homes" - Identifies and encourages evidence-based approaches for chronic care. - Align payment incentives to providers with goals to improve care.	DSHS & DOH	January 2007

What is the goal for expanding chemical dependency treatment?

Goal: Increase chemical dependency treatment services, serving 25,179 aged, blind, disabled, and other Medicaid-eligible adults in Fiscal Year 2006.

Treatment Expansion Progress

Statewide, Adults Meeting Expansion Criteria



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY06 Goal	7,448	9,202	10,895	12,502	14,046	15,610	17,181	18,679	20,373	21,966	23,569	25,179
FY06 Actual	7,519	9,105	10,279	11,454								
Baseline	6,906	8,120	9,271	10,338	11,340	12,361	13,391	14,348	15,501	16,553	17,615	18,684

Analysis:

■ **Service expansion through the Division of Alcohol and Substance Abuse will cost $33 million in 2005-2007.**

•However, treatment expansion is expected to save $24 million (total), $13 million GF-S in medical programs, and $7 million (total), $3.4 million GF-S in long-term care, this biennium.

• Service levels are increased for aged, blind, disabled and General Assistance Unemployable clients with chemical dependency problems.

• The number of clients served will be phased in over the biennium.

Data notes: SOURCE: DSHS-Research and Data Analysis. Division of Alcohol & Substance Abuse (DASA) Treatment Expansion Client Monitoring Report. Client data from TARGET, MMIS, and CSDB. DA will conduct the cost-offset analysis of Treatment Expansion, and should be considered the "gold standard" for Treatment Expansion progress.

How is chemical dependency treatment expansion going?

Goal: Admit an additional 5,000 Medicaid Disabled clients into treatment by June 30, 2006.

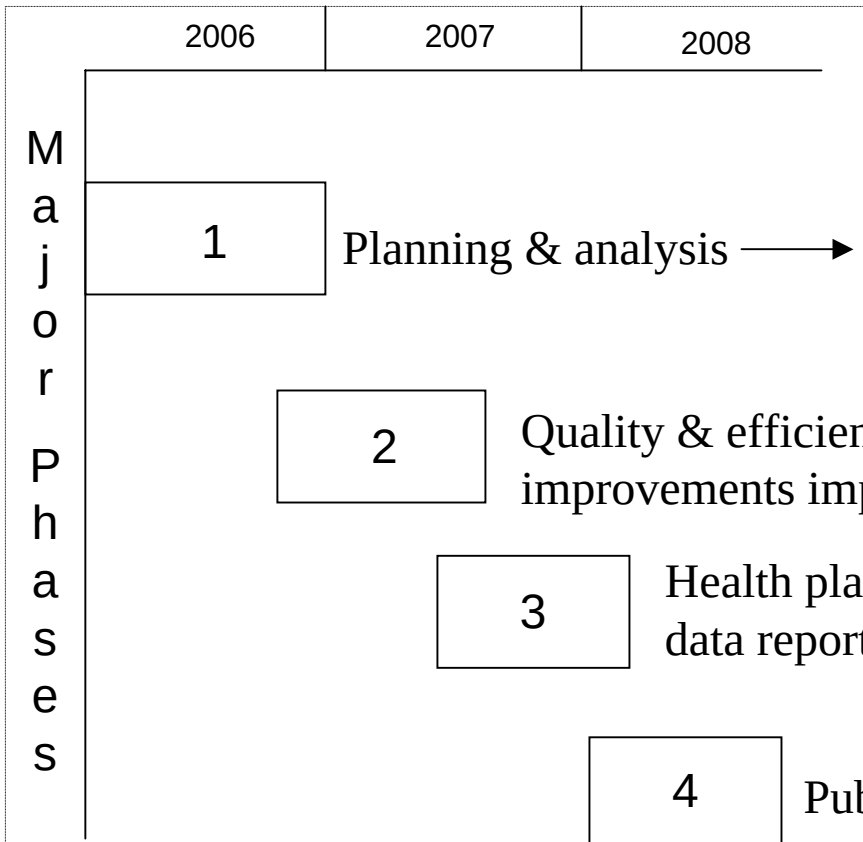
Analysis:

- Two sub-populations of clients are entering treatment at the expected rate. Through February 2006, Family Medical clients are at 87% of expected and General Assistance Unemployable clients are at 106% of expected.*
- Two sub-populations are well the below expected rate. Through February 2006, only 67% of the expected number of aged clients, and 68% of the expected Medicaid Disabled clients have entered treatment.*
- The greatest cost-offset comes from treating Medicaid Disabled clients. This population also comprises the largest percentage of expected clients to be served in treatment expansion.

Action	Person Responsible	Due Date
Residential treatment capacity for treatment expansion clients will be expanded through reallocating under-expenditures to providers able to increase services.	DSHS-DASA Regional Administrators	30-Jun-06
Outpatient treatment capacity for treatment expansion clients will be enhanced through additional contracts with providers not currently under contract.	DSHS-DASA Acting Director	30-Jun-06
Adjust treatment modalities to better meet the needs of clients living in nursing homes and adult family homes. One adult residential care facility has been identified in each region to serve as pilot sites for the Group Care Enhancement model.	DSHS-DASA Regional Administrators	2 projects by 30-Jun-06 Remaining 4 projects by 31-Dec-06

Data notes: SOURCE: DASA Treatment Analyzer. Treatment Analyzer is a web-based management tool used by DASA staff, counties, and providers to monitor performance. Treatment Analyzer data is drawn from the DASA TARGET database and is subject to changes as providers update and edit treatment information.

What is the plan for making health care quality & efficiency data publicly available? ("transparency")



2006 Milestones	Status
Identify other national/state models	Complete
Review necessary business requirements	50%, on time
Develop data access strategy with Puget Sound Health Alliance	75%, on time
Specify strategy for Washington	25%, on time
Negotiate with health plans to submit data to national database	0%, on time

Interim Targets: 100% of HCA members enrolled in health plan that provides quality and efficiency data to benchmarking database by 2008. Healthcare quality and efficiency data publicly available by 2008.

Analysis: This project is on schedule. Challenges include working successfully in collaborative environment with other regional purchasers to fully develop data acquisition and analysis strategy.

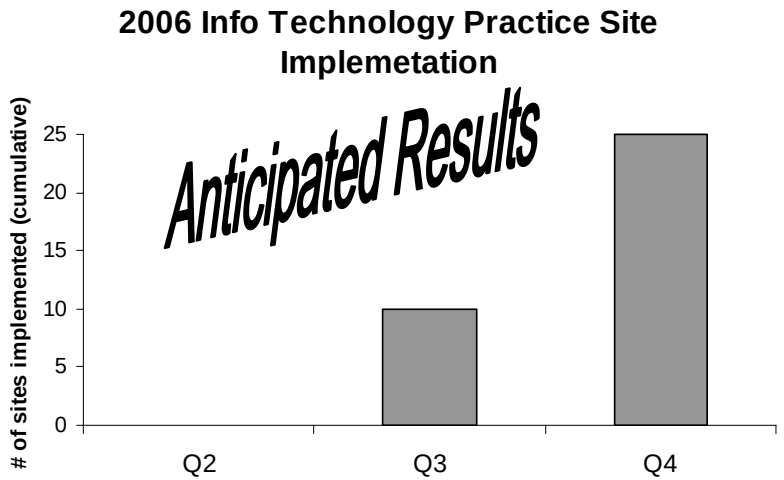
How will we increase use of electronic medical records?

Objective:
Reduce the cost of health care in WA by improving quality and efficiency of health care delivery system

Strategy:
Encourage all hospitals, integrated delivery systems, and providers in the state of Washington to adopt health information technologies by the year 2012

Performance Measure:
1. Develop recommendations through Health Information Infrastructure Advisory Board (HIIAB) to increase adoption of health information technology
2. Implement pilot program to increase adoption of health information technology

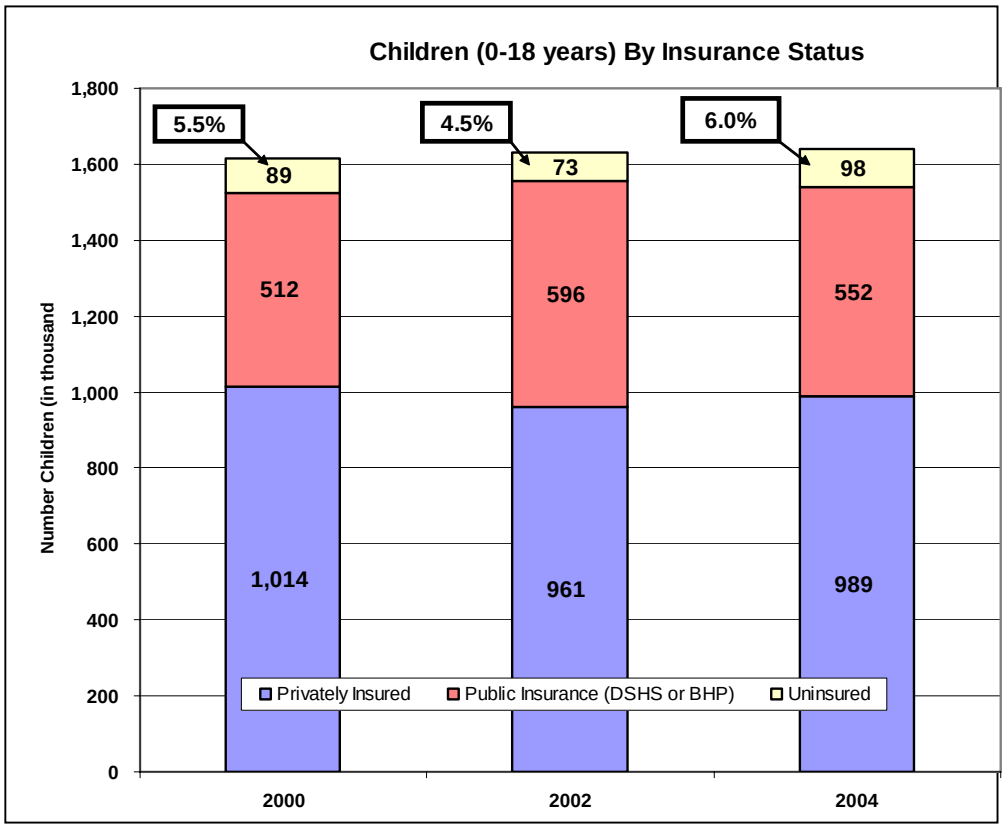
Target:
1. HIIAB recommendations complete by December 2006
2. 25 practice sites implemented by December 2006



Major Project Phases
- 2005 – Planning and analysis
- 2006 – Guide SHB 2573 through Legislature, Development of Recommendations, Implement Pilot Project

Notes: HCA will also provide consultation with Department of Corrections on the demonstration project outlined in Section 4 of SHB2573.

What is the insurance status of children in Washington?

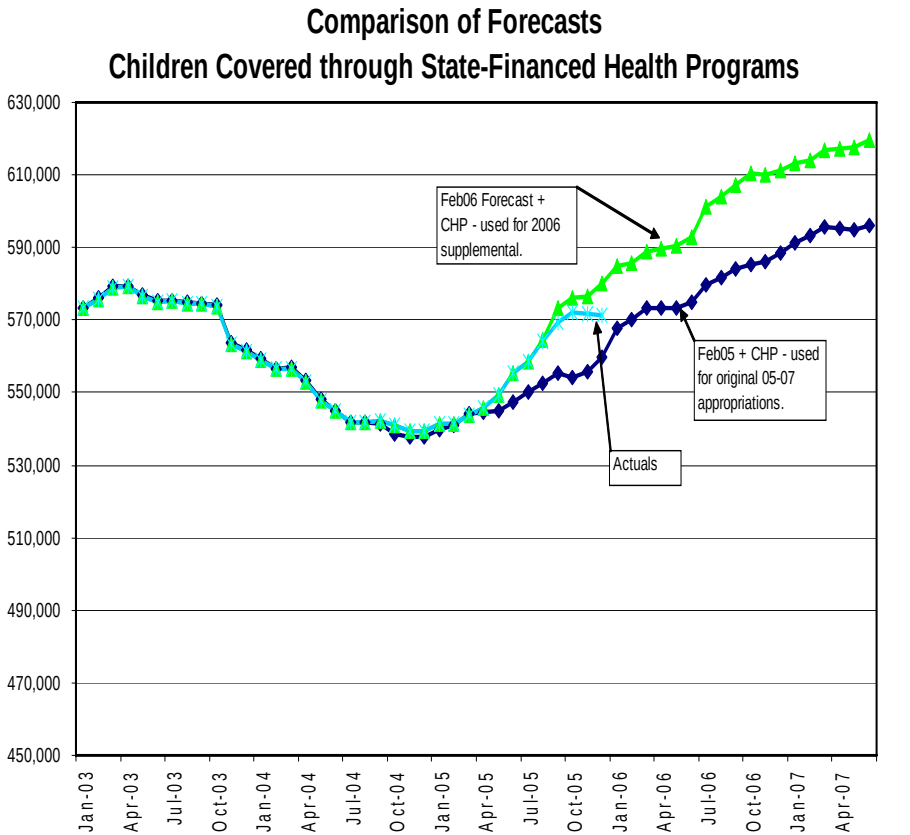


Factors That Affect Coverage

- **Natural increase in state population**
- **Public funding for low-income health coverage (Medicaid covers 1/3 of all children)**
- **Continuing high increases in health insurance costs erodes private and public coverage**
- **Employer-based coverage becomes more unaffordable for families as employers shift a bigger share of health coverage costs to employees**
- **Structural economic changes, such as shift from manufacturing to service-sector jobs, have played a role in private coverage erosion in recent years**

Data Notes: *Source: Washington State Population Survey – 2004 (biannual). The survey will be updated for 2006 in September 2006.*

Is the expansion of state-paid health coverage for children going as expected?



Analysis:

■ **The actual number of children enrolling in state-funded health coverage is not increasing at the level anticipated in the most recent forecast. CFC and DSHS staff are investigating.**

• The budget assumed that 75,600 more children would be added between March 2005 and June 2007.

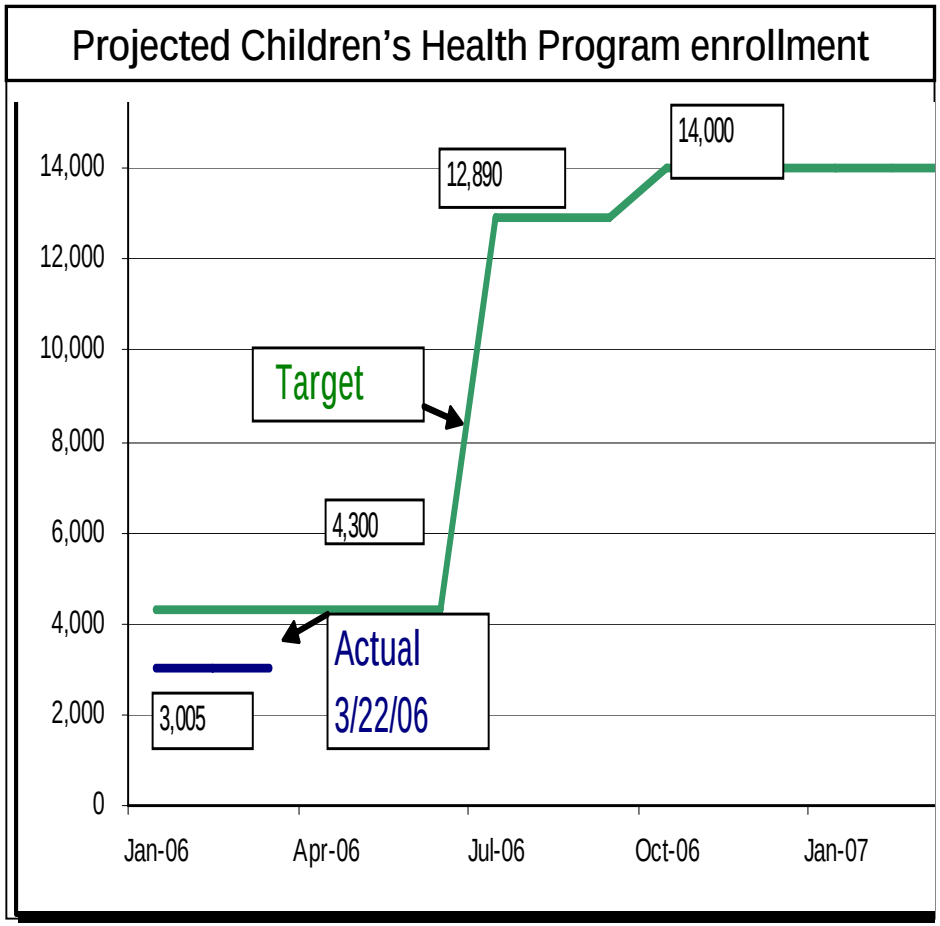
• In December 2005, there were 8,500 fewer children on the caseload than was anticipated in the February 2006 forecast.

• Citizenship verification requirements under the federal Deficit Reduction Act of 2005 may put further downward pressure on caseloads.

Actions	Who	Due
Work with the Caseload Forecast Council (CFC) staff on reasons for the decline.	HRSA forecast workgroup	May 06
Work with the Caseload Forecast Council workgroup to develop June 2006 forecast out to June 2009.	HRSA forecast workgroup	May 06

Data notes: *DSHS MMIS eligibility file and HCA Basic Health enrollment file.*

What is the status of the Children's Health Program expansion?



Analysis:

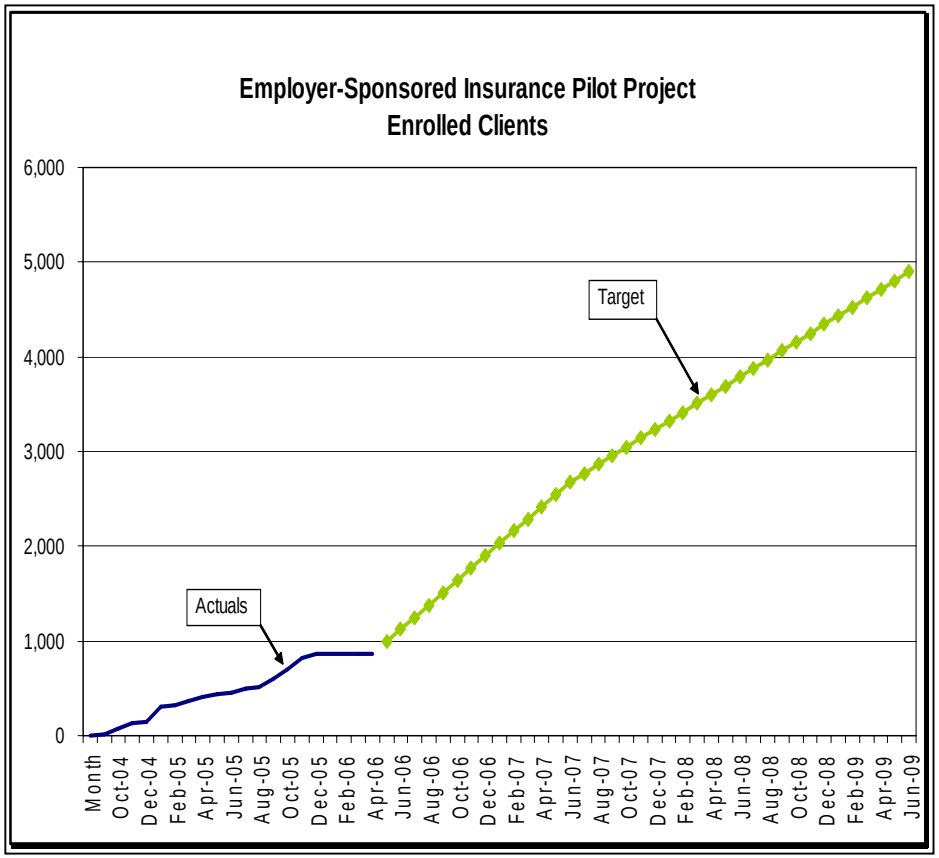
■ **Number of approved CHP* applications is below the original target:**

- 37% of applications processed to date have been denied - the majority for income above 100% federal poverty level (FPL).
- Demographics have changed since 2002. Many families are now working in service industry.
- Of 10,947 children on the waiting list, only 7,000 are now expected to meet eligibility standards.

Actions	Who	Due
Supplemental budget added $10.7 million for CHP		Done
Additional staff hired to process CHP applications	DCS**-HRSA	6/30/06
Enroll at least 4,300 in CHP	DCS	6/30/06
Consider using outreach	DCS	6/30/06
Analyze CHP eligibility rates	DCS	6/30/06
Consider 2007 legislation to raise eligibility income levels above 100% of FPL.	HRSA	Fall 2006

Data notes: **CHP is the Children's Health Program, which provides health care to non-citizen children in families with incomes up to 100% of the FPL. **DCS is the Division of Customer Support within the Health & Recovery Services Administration in DSHS.*

What is the status of the Employer-Sponsored Insurance expansion?



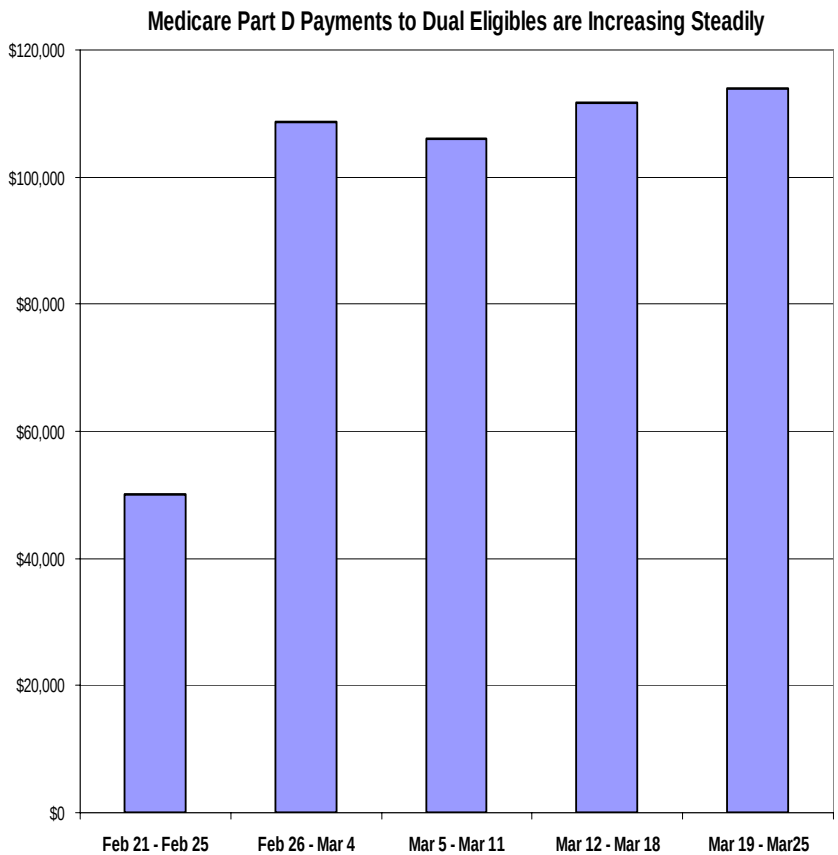
Analysis

- ESI pilot makes payments for families' employee premium costs when their employer-sponsored coverage is cost-effective for state. Can include coverage for both children and employee.
- Medicaid family member also receives wraparound services from Medicaid when they are not covered by employer plan.
- Enrollment in pre-pilot test reached 860 clients as of December 2005.

Actions	Who	Due
Supplemental budget included funding for additional ESI staff and project expansion	Project manager	Complete
Project to enroll 1,800 clients and cover operating costs by June 2007	Project manager	6/2007
Total targeted net savings of $3 million by June 2009.	Project manager	6/2009

Data notes: *Medicaid Management Information System (MMIS) and ESI project's tracking system.*

What is the status of Medicare Part D co-payments?



Analysis:

■ **The Governor directed DSHS to pay the cost of Medicare pharmacy benefit co-payments for clients eligible for both Medicare and Medicaid.**

• Amounts paid are less than originally estimated. However, it is expected that as more pharmacies develop the capacity to claim, HRSA will see spikes in claims retroactive to implementation date of February 21, 2006.

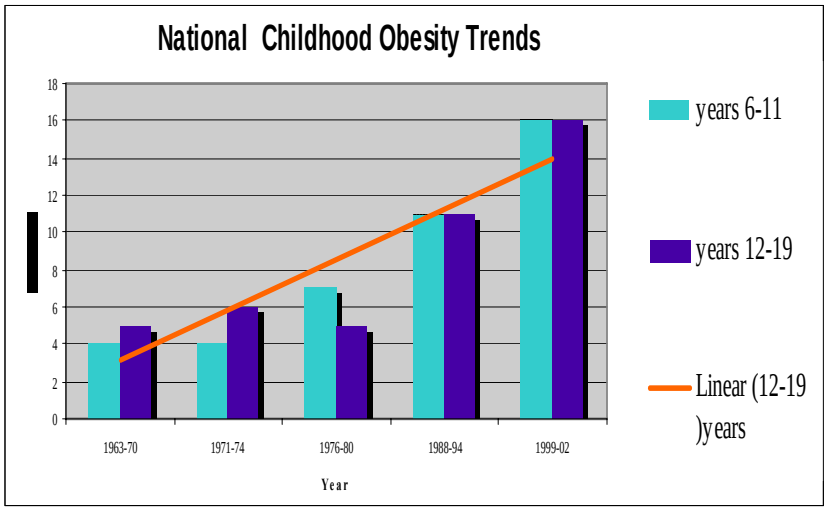
• The number of claims paid at the highest level ($5) has declined slightly each week

•DSHS has paid co-payments for 46,545 dual eligible clients from 2/21/06-3/26/06, at a total cost of $494,000.

Actions	Who	Due
DSHS continues to analyze claims paid on a daily basis	DAIS* - HRSA	Ongoing

Data notes: Source MMIS claims data.
*DAIS is the Division of Audit and Information Systems

Why are we focusing on improving nutrition in schools?



Societal Influences on Obesity

- Urban/Suburban designs discourage walking and physical activity
- Reduced access to and affordability for fruits, vegetables and other nutritious foods
- TV and video games replace active play and exercise
- Decreased opportunities for physical activity at school

Washington Childhood Obesity

- Obesity in Washington's children is on the rise
- 1/4 of WA young people* are overweight or at risk of becoming overweight
- Young people have poor diets (see next slide)
- Over 1/3 of students are trying to lose weight

Risks of Obesity to Children

Physical Health

- Type 2 diabetes
- Chronic diseases
- Eating disorders
- Overweight as adult

Emotional Health

↓Academic performance

- Shame, self-blame
- Low self-esteem
- Stigma, discrimination, bullying

Sources: *Washington:* The Healthy Youth Survey (HYS), 2004. *National:* CDC and NHANES, age adjusted by the direct method to the year 2000 US Bureau of the Census estimates using age groups, 20-39, 40-59, 60-74 years. IOM Reports.

*** Young People =** 8th, 10th, and 12th Graders

What are we doing to improve nutrition in schools?

Chart of Key Measures

•Are schools serving healthier foods?

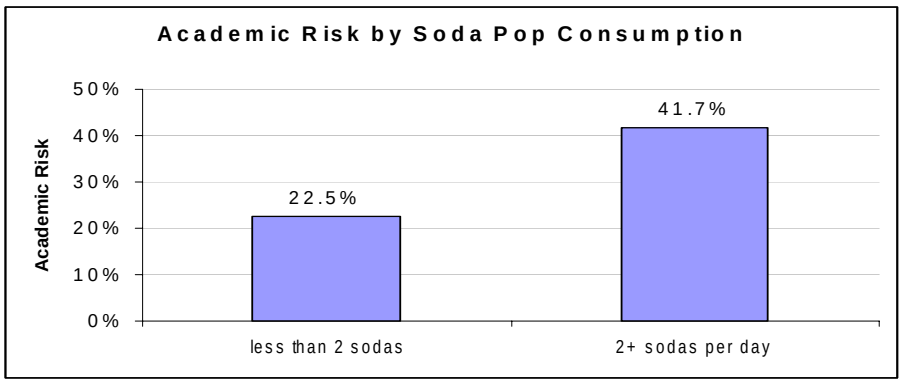
•Are young people eating healthier foods?

•Are young people getting healthier?

Statement of the Problem

•**Health Status:** Rise in childhood obesity, diabetes as well as other risks associated with increased weight gain.

•**School Nutrition:** Over 25% of surveyed 8th, 10th, and 12th graders reported drinking two or more sodas a day. **Odds for academic risk were 69% higher for students who drank 2+ pops in a day.**



Challenges

Fragmentation:

•School nutrition one part of children's health;

•School structure: independent (elected officials) and very locally controlled. (296 districts)

•Baseline data on what works and on district nutrition policies not readily available.

Funding and Authority:

•DOH has <1FTE & <$500,000 federal funds for pilot activities. All at risk.

•DOH is not in the driver's seat.

•Public and Private partnerships necessary for success.

Actions and Milestones

DOH Direct Support to Schools:

• Provide schools "best nutritional practices" information and appropriate health ed curricula.

•Recognize and reward all school boards upgrading food programs.

•Revenue replacement workshops for school stores.

Interagency Collaboration (OSPI):

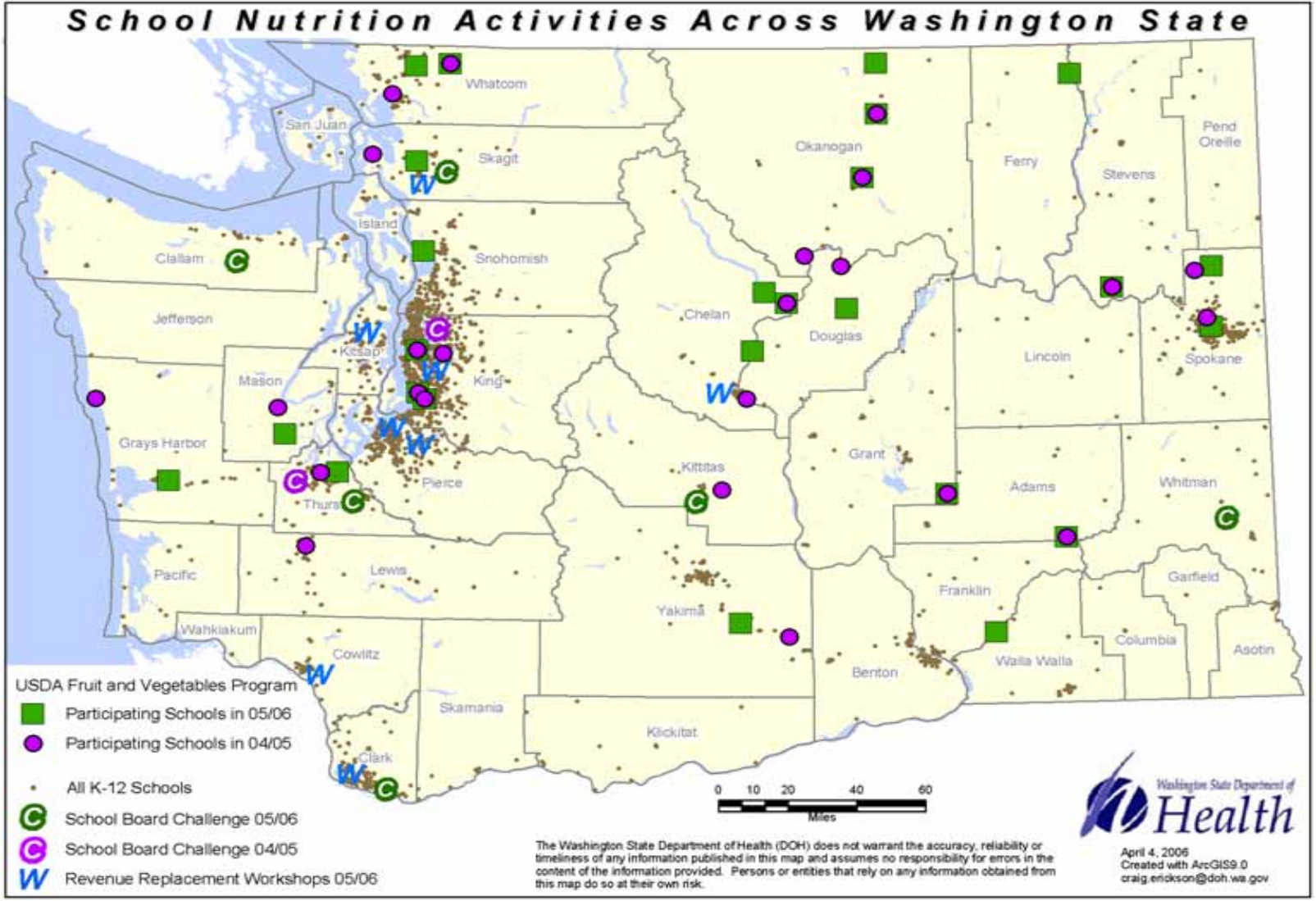
•Free fresh fruits & vegetables to select pilot schools.

Data/Assessment (UW):

•RWJ Research Grant: How do school nutrition practices affect student diet?

Data Notes: Current: The Healthy Youth Survey (HYS) and the School Health Profiles Survey (Profiles)

Proposed: RWJ Grant: Key informants in each school district (academic, food service administrators and staff)



Participation in School Nutrition Pilots 2004-2005

Fresh Fruit and Vegetable Program Involves:
Fewer than 1 percent of Washington's 2,008 public schools

Revenue Replacement Workshops for School Stores:
Almost 3 percent of the 296 school districts held a workshop

School Board Challenge:
2 percent of 296 school boards received a challenge award over two years

Supplemental Slides

- How will we incorporate outcome measures in state contracts?
- Children's enrollment trends in Medicaid, State Children's Health Insurance Program, and Basic Health.
- Status of DSHS Medicaid cost savings initiatives.

How will we incorporate outcome measures in state contracts?

DOH, DSHS & HCA workplan for implementation of Governor's Outcomes Directive

Action	Agency	Status
Establish Health Outcomes Advisory Committee (HOAC).	DOH, DSHS & HCA	Agencies met to identify tasks. Completion Date: May 2006
Compile current state agency health outcome measures.	HOAC	Completion Date: June 2006
Implement strategies to incorporate measures into health plan contracts to improve outcomes.	HOAC	Completion Date: June 2006
Amend CY 2007 health plan contracts as needed to incorporate outcome measures.	DSHS & HCA	Completion Date: July 2006
Evaluate measures, including trends and evidence of improvement.	HOAC	Completion Date: January 2007
Identify national measures for prevention, wellness chronic illness and method to access health disparities.	HOAC	Completion Date: January 2007
Work with local, state, national quality initiatives to improve health outcomes.	HOAC	To Be Determined
Develop recommendations on how state-purchased health care improve outcome measures and lessen health disparities.	HOAC	Completion Date: January 2008
Examine feasibility of collecting fee-for-service (FFS) outcome measures and if appropriate develop plan to implement.	HOAC	To Be Determined
Publicly report these outcome measures by July 2008.	DSHS & HCA	Completion Date: July 2008

Health Care – Cover All Washington's Children Initiative

Children's enrollment trends in Medicaid, SCHIP and Basic Health

GMAP - State Financed Health Care Coverage for Children

Month	Medicaid				State Children's Health Insurance Program	Children's Health Program	Basic Health Program	Total Children's	
	Children's Medical (incl. Foster Care, Adoption Support)	Family Medical	Disabled Children	Pregnant Women				Total Enrollees	Increased Enrollment from March05 Baseline
Jan-04	335,438	181,557	15,887	2,007	10,059	0	14,107	559,055	
Feb-04	332,064	181,722	15,929	2,024	10,510	0	14,229	556,478	
Mar-04	328,921	184,680	15,978	2,074	10,948	0	14,067	556,668	
Apr-04	325,333	185,253	16,007	2,077	10,302	0	14,085	553,057	
May-04	319,741	185,284	16,066	2,089	10,690	0	13,895	547,765	
Jun-04	316,294	185,818	16,105	2,102	11,212	0	13,375	544,906	
Jul-04	313,025	185,212	16,154	2,067	11,970	0	13,223	541,651	
Aug-04	311,534	186,273	16,231	2,074	12,461	0	13,286	541,859	
Sep-04	310,481	187,036	16,258	2,057	13,199	0	13,349	542,380	
Oct-04	308,635	186,972	16,278	2,047	13,572	0	13,454	540,958	
Nov-04	306,391	187,437	16,249	2,049	13,835	0	13,439	539,400	
Dec-04	305,890	187,628	16,302	2,038	13,890	0	13,651	539,399	
Jan-05	306,185	188,718	16,367	2,064	13,846	0	14,111	541,291	
Feb-05	305,994	188,771	16,421	2,051	13,919	0	14,414	541,570	
Mar-05	306,936	189,609	16,453	2,098	14,228	**0**	14,647	**543,971**	
Apr-05	310,399	189,020	16,459	2,093	12,754	0	14,867	545,592	1,505
May-05	314,707	187,971	16,463	2,086	13,134	0	14,867	549,228	4,928
Jun-05	321,744	186,936	16,501	2,085	13,173	0	14,807	555,246	10,697
Jul-05	328,287	184,052	16,549	2,096	12,990	0	14,403	558,377	13,094
Aug-05	334,333	184,130	16,590	2,092	12,868	0	14,136	564,149	20,178
Sep-05	340,520	183,698	16,621	2,086	12,655	0	13,887	569,467	25,496
Oct-05	344,660	182,512	16,675	2,088	12,290	0	13,889	572,114	28,143
Nov-05	346,273	181,059	16,705	2,089	12,016	0	13,694	571,836	27,865
Dec-05	345,651	180,519	16,707	2,089	11,859	0	13,694	570,519	26,548

Data notes: *Actuals through December 2005.. Children's Health Program did not start until January 2006.*
Data sources: *MMIS, Basic Health tracking*

DSHS – 2005-07 Biennial Medical Care Savings Initiative

What is DSHS doing to achieve medical savings?

Summary of medical savings

Savings as calculated over time	
1. Initial savings assumed in appropriations	$45,377,000
2. LESS: Adjustments in 06 supplemental budget	($10,406,000)
3. Adjusted savings target for 2006-2007 biennium	**$34,971,000**
Status through December 05	
Targeted initiative savings	$8,742,750
Savings (preliminary estimates)	**$7,270,053**

Actions/Analysis	Who	Status
Added neurontin to list of drugs requiring prior authorization and perform provider reviews.	Division of Medical Mgmt. (DMM)	On target
Expand patients requiring review (PRR) project - client education and provider participation.	PRR manager	On target
Medical nutrition: develop a new protocol and restructure rates	DMM and Division of Business & Finance (DBF)	On target
Improve collection efforts and provider audit reviews.	Audit and Coordination of Benefits. Office of Financial Recovery	Under target due to difficulty in hiring audit staff
Monitor durable medical equipment purchases. Establish strategy for supplies/wheelchair purchases	DMM and DBF	On target